David Parmer MA, LPC

Today's Date ____ /____ /_____

Patient's Name: _____

You are requesting: (check one)

_____ individual counseling

_____ marital counseling, or

_____ family counseling services

Payments and Insurance Reimbursement

Individual counseling sessions are $160.00.
Marital, couples, and/or family counseling sessions are $200.00.

Initial visits are 50-minute sessions. If the session is shorter or longer the fee may be adjusted accordingly. If I am an in-network provider for your insurance company, our office will file for you. Insurance must be verified prior to your first visit by calling 281-907-1314 or visiting www.davidparmer.com. You will be responsible for your co-pay or deductible. Should your insurance company not pay your claims your balance is your financial responsibility.

If I am not in your insurance network, you will be provided with a receipt that you may file with your insurance company. The fee is due at the time of the session. Please note, if insurance is being before they will reimburse you for my services, I will discuss with you the diagnosis I plan to render, if you wish, before your file claims with your insurance company, Any diagnosis made will become a part of your permanent health record.

Initial of the person financially responsible: _____

Appointments and Cancellations

Appointments can be scheduled by calling 281-907-1314 or by visiting www.davidparmer.com. I do request 24-hour advance notice for cancellations in order to use the time for another patient. With less notice you will be charged/billed the amount for the session.

Initial of the person financially responsible: _____

Confidentiality

I will keep notes regarding your counseling sessions; however, those notes will not be revealed to anyone without your written permission. I cannot disclose to anyone that you are in counseling without your written permission. The only times that confidentiality could be broken is if you disclose abuse/neglect of a child or the elderly. If it is understood that you could harm yourself or others, your guardian (if the client is a minor) and/or law enforcement will be notified. Confidentiality could be broken if a courtroom judge orders me to disclose information gathered in counseling sessions. Also, if you are filing information with your insurance company, they may require disclosure of some details to pay for your counseling sessions.

Initial of the person financially responsible: _____

Contacting David Parmer

If you need to contact me between sessions, please call 281-907-1314 or visit www.davidparmer.com. You may leave a message and I will return your call usually within 24 hours or less. In an emergency you may need to call 911 or go to the nearest hospital emergency room.

Initial of the person financially responsible: _____

Testifying in Court

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings neither you nor your attorney's, nor anyone else acting on your behalf will call me to testify in court or at any proceeding nor will a disclosure of the psychotherapy records be requested. Should I receive a subpoena by the court, my individual hourly fee ($200.00) is applied time involved.

Initial of the person financially responsible: _____

Patient Information

First and Last Name _____

Spouse's Name _____

Street Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

E-Mail Address _____

Date of Birth _____

Relation Status (Circle One)

Single Married Separated Divorced Living with partner

Name of School / Grade _____

Employer _____

Medications _____

Medical Doctor's Name _____

I learned about David Parmer through _____

I will notify you if there are any changes in my health status or the above information.

Adolescent Signature _____ **Date** _____

Guardian Signature _____ **Date** _____

Person Responsible for Payment

(if different from above information)

First and Last Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-Mail Address _____

Date of Birth _____

Employer _____

Medications _____

Doctor's Name _____

I understand and agree that I am responsible for the balance on my account at the time of professional services being rendered. The above answers on the attached document are true and correct.

Initial of the person financially responsible _____

Consent for Treatment of an Adult (18 or older)

I _____ (Adult Patient), hereby give my consent to be treated by David Parmer, MA, LPC.

Consent for Treatment of a Minor (under the age of 18)

I _____ (Guardian), hereby give my consent

for _____ (Client) to be treated by David

Parmer, MA, LPC.

The above-named patient is a minor (under the age of 18) and is under my legal guardianship.

Adolescent Signature _____ Date _____

Guardian Signature _____ Date _____

As the guardian of an adolescent – if you are divorced – you should bring a copy of the divorce decree to your first counseling appointment. The only exception will be if both biological parents are present for the appointment.

Counseling cannot be provided for children of divorce without a copy of custody documents.

Check all symptoms you have been experiencing:

( ) recent weight gain How much? _____

( ) recent weight loss How much? _____

( ) difficulty falling asleep(insomnia) ( ) excessive sleeping ( ) fatigue

( ) middle of the night awakening ( ) decreased energy ( ) lack of motivation

( ) restlessness or agitation ( ) decreased appetite ( ) increased appetite

( ) frequent mood swings ( ) frequent anger ( ) irritability

( ) complaints of despair, hopelessness, worthlessness ( ) inattention

( ) inability to experience pleasure ( ) inability to express feelings

( ) withdrawal from others ( ) difficulty concentrating

( ) loss of libido ( ) loss of thought process

( ) difficult focusing resulting in unfinished task

Are you presently having thoughts of suicide? ( ) no ( ) yes

If yes, please provide more information: _____

_____

Have you ever made a suicide attempt? ( ) no ( ) yes

If yes, please provide more information: _____

_____

MEDICAL AND PSYCHIATRIC HISTORY

List any medical problems: _____

_____

Are you currently taking any medication? ( ) no ( ) yes

If yes, list any medication you are currently taking: (drug name, amount, mg.)

Drug Name _____

Amount (MG) _____

Do you have a history of the following?

( ) Hepatitis ( ) Mononucleosis ( ) Seizures ( ) Renal Kidney problems

( ) Diabetes ( ) Heart disease ( ) High blood pressure

( ) Low blood pressure

If any significant med/psych problems with any family member please list:

1. **Family member: _____ problem: _____**
2. **Family member: _____ problem: _____**
3. **Family member: _____ problem: _____**

Have you ever had psychiatric treatment? ( ) no ( ) yes

If yes, please describe: Date: _____ Provider: _____

reason:

_____

HISTORY OF SUBSTANCE USE AND/OR ABUSE:

Have you ever used drugs? ( ) no ( ) yes

Substance: _____

Age began: _____

Frequency/amount: _____

Last time used _____ Have you ever been in treatment (hospital or outpatient) for drug and or alcohol abuse?

( ) no ( ) yes If yes, please describe, providing date, provider and type of treatment:

_____

Do you use any tobacco product? ( ) no ( ) yes

If yes, what type _____ how much? _____

HISTORY OF ABUSE:

Have you ever been a victim of physical / emotional / sexual abuse? (Circle all that apply)

MARITAL / SOCIAL HISTORY

List any additional people living in the household:

Names:

_____

_____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Other

If married how many years? _____

How many times married? (1) (2) (3) (4)

Describe past / present marriage: _____

_____

Do you have children? ( ) no ( ) yes If yes, how many? _____

Names, Ages, and relationship (biological, step, adopted, foster)

_____

_____

VOCATIONAL AND OCCUPATIONAL HISTORY

Highest Education Level: ( ) High school ( ) College ( ) GED ( ) Technical school ( ) Master

What was your major / skill learned?

_____

Current Occupation:

_____

Length of employment: _____ Do you enjoy your work? ( ) yes ( ) no

Please list any work stressors: _____

_____

Additional Comments:

_____

_____

_____

_____

_____

_____

_____

David Parmer Counseling
26113 Oak Ridge Drive
Suite C
The Woodlands, Texas 77380
281-907-1314
www.davidparmer.com

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting us at the office.

By signing this form, you consent to our use and disclosure of protected information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing except where we have already made disclosures in reliance on your prior consent.

Please list any persons we may speak with about appointment times/dates.

_____ _____ _____

(name/relationship) **(name/relationship)** **(name/relationship)**

If you would like other information released please ask for a release of information and complete before leaving the office.

Patient (Print): _____

Patient/Guardian Signature: _____

Date: _____

Patient Name: _____

Patient Address: _____

E-mail: _____

1. **RISK OF USING EMAIL**

Transmitting patient information by e-mail has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:

a) **E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.**

b) **E-mail senders can easily misaddress an e-mail.**

c) **Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.**

d) **Employers and on-line services have a right to inspect e-mail transmitted through their systems.**

e) **E-mail can be intercepted, altered, forwarded, or used without authorization or detection.**

f) **E-mail can be used as evidence in court.**

g) **E-mails may not be secure, including at David Parmer Counseling, LLC and therefore it is possible that the confidentiality of such communications may be breached by a third party.**

2. **CONDITIONS FOR THE USE OF E-MAIL**

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of e-mail information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) **E-mail is not appropriate for urgent or emergency situations. Provider cannot guarantee that any E-mail will be read and responded to within any particular period of time.**

b) **E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via e-mail.**

c) **All e-mail will usually be copied and pasted into the patient's electronic medical record.**

d) **Office staff may receive and read your messages.**

e) **Provider will not forward patient identifiable e-mails outside of David Parmer Counseling LLC without the patient's prior written consent, except as authorized or required by law.**

f) **The patient should not use e-mail for communication regarding sensitive medical information.**

g) **The provider is not liable for breaches of confidentiality caused by the patient or any third party.**

h) **It is the patient's responsibility to follow up and/or schedule an appointment if warranted.**

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a) **Avoid use of his/her employer's computer.**

b) **Put the patient's name in the body of the e-mail.**

c) **Key in the topic (e.g., medical questions, billing question) in the subject line.**

d) **Inform Provider of changes in his/her e-mail address.**

e) **Acknowledge any e-mail received from the Provider.**

f) **Take precautions to preserve the confidentiality of e-mail.**

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patient by e-mail. If I have any questions I may inquire with David Parmer.

Patient Signature: _____

Date: _____